Health, Welfare Public Service

300 3
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUN 20 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

157 022925
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5420

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis — Inside Limits: Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 38 Enroute City Hospital — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Illinois b. COUNTY: Shelby
c. CITY OR TOWN: Moweaqua — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS: 32 (If outside, give location) — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Almittie Middle: B. Last: Stogsdill

4. DATE OF DEATH: Month: June Day: 8 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 22,1898

9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): McLeansboro Ill

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alec Glover

14. MOTHER'S MAIDEN NAME: Lucinda Hay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 332-22-7647

17. INFORMANT Address: Wayne Musselmann, Decatur, Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Peritonitis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Ruptured Peptic Ulcer
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 540.1

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. p. m. Month, Day, Year:

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from ____, to ____ and last saw her/him alive on ____
Death occurred at 656 A m on the date stated above; and to the best of my knowledge, from the causes stated

22a. SIGNATURE (Degree or title): James M Kelly Deputy Coroner

22b. ADDRESS: 1300 Clark

22c. DATE SIGNED: 6-10-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 6-8-57

23c. NAME OF CEMETERY OR CREMATORY: Local

23d. LOCATION (City, town, or county) (State): Argenta Illinois

24. FUNERAL DIRECTOR ADDRESS: Albert H.Hoppe 4700 Washington

25. DATE RECD. BY LOCAL REG.: JUN 10 '57

26. REGISTRAR'S SIGNATURE: Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Robert M. Murray

3749
Licensed Embalmer No.

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.